

Chapter 6

Conclusion and recommendations

6.1 Throughout this inquiry, the Senate Community Affairs References Committee (committee) heard how people living in Australia's rural and remote communities face a myriad of barriers to accessing quality mental health services.

6.2 These barriers range from the obvious, such as the actual presence or availability of services and health professionals in an area, to the more subtle, such as the attitudes towards mental health within the community or the effects of social determinants of health like socioeconomic status or employment.

6.3 Rural and remote mental health services across the country represent a patchwork of strategies, models and approaches funded by all levels of government. Few appear to be fully meeting the needs of the communities which they service.

6.4 The recommendations proposed by the committee in this chapter seek to address what it considers to be the most pressing and prevalent of concerns raised by submitters and witnesses to this inquiry.

A strategic response to deliver a complex service

6.5 The delivery of health services across a nation as geographically large and as culturally diverse as Australia is extremely complex. Added to that complexity are the differing health responsibilities of the three levels of government in Australia, combined with the reality that in many rural locations, service provision crosses state and territory jurisdictional boundaries.

6.6 In recognition of this complexity, a range of national, state and territory health strategies have been developed to assist in the design and delivery of health services. While there are strategies for mental health services, which make mention of the complexity of rural and remote service delivery, and strategies for rural and remote health service delivery, which mention mental health services, what has been lacking to date is a strategy specifically for mental health and wellbeing services delivered in the distinct service environments found in rural and remote Australia.

6.7 In rural and remote communities, the causes of mental illness are often different, the culture of communities is different and the service solutions must therefore be different to those found in urban centres. Until there is a strategy that acknowledges the different context of rural and remote communities, mental health service delivery in rural and remote locations will continue to be a fragmented approach with band-aid solutions.

6.8 The committee supports the recommendation endorsed by many expert organisations, including the Royal Flying Doctor Service, that the National Mental Health Commission should be funded and tasked with the development of a national rural mental health strategy. This strategy should be informed by Primary Health Network service mapping in rural and remote areas and other key data that identifies service shortfalls. The National Mental Health Commission should also be tasked with

monitoring and overseeing implementation of the strategy, reporting back directly to government.

Recommendation 1

6.9 The committee recommends the development of a national rural and remote mental health strategy which seeks to address the low rates of access to services, workforce shortage, the high rate of suicide, cultural realities, language barriers and the social determinants of mental health in rural and remote communities.

Recommendation 2

6.10 The committee recommends that the national rural and remote mental health strategy is subject to an implementation and monitoring framework which includes regular reporting to government and that these reports are tabled in Parliament.

6.11 Additionally, the committee considers that the development of a national rural and remote mental health strategy should take into account matters raised in this report, including but not limited to the improved outcomes seen by services offering a 'no wrong door' approach to service delivery, ensuring that patients are treated holistically and receive the support they need without entry barriers.

6.12 The committee believes that in order to be effective, a national rural and remote mental health strategy must also seek to address the social determinants of health identified in this report which are fundamental to improving mental health services and suicide prevention in regional, rural and remote communities around Australia.

6.13 Furthermore, the committee does not believe that work on a rural and remote mental health strategy should halt immediate progress to solve pressing concerns that could be addressed now, or that would not require a strategy to develop solutions. Some of these concerns and related recommendations are discussed below.

Putting the community at the centre of the approach

6.14 During the course of this inquiry, the committee travelled to rural and remote locations throughout Australia to gain an understanding of how mental health service delivery impacts different communities across Australia, each with different needs and a different service context. The committee spoke to locals from diverse backgrounds, including mental health consumers, farmers, miners, Aboriginal and Torres Strait Islander peoples, local councils, teachers, nurses, doctors, academics, and committed volunteers at the front lines of suicide prevention.

6.15 One clear message came from these very distinct communities. From small towns in Tasmania to Aboriginal communities in the Northern Territory and from mining towns in Queensland to agricultural regions in Western Australia, the committee heard that the voices and experiences of local communities are not being listened to in service design and delivery.

6.16 While there is often some level of community consultation, this is often at the tail-end of the process when a provider has been selected and the service has already

been commissioned and largely designed. This near universal lack of local input at the very start of the service commissioning process has resulted in mental health and wellbeing services that are designed in urban centres, by and for the needs of people who live in urban centres, and then tweaked to create the appearance of a local approach or to accommodate the travel needs of urban staff to deliver the service in a rural or remote context.

Recommendation 3

6.17 The committee recommends an overarching approach is taken by all parties to guarantee that the design of mental health and wellbeing services starts with local community input to ensure that all rural and remote mental health services meet the measure of 'the right care in the right place at the right time'. This needs to be informed by best practice and international knowledge.

The role of the National Disability Insurance Scheme

6.18 The committee is encouraged by the creation of a psychosocial disability stream within the National Disability Insurance Scheme (NDIS) to improve the process of accessing the NDIS and to provide support to people with severe and persistent mental health issues.

6.19 The committee notes that at the time of this inquiry, there was limited information available regarding the implementation of the psychosocial disability stream, and in particular how it will be rolled out in rural and remote Australia.

6.20 The committee is concerned by the accounts it received that many rural and remote Australians have experienced issues applying for the NDIS and accessing appropriate mental health services through their NDIS plan. These issues included: a deficit of knowledge about the NDIS by health professionals; assessors, planners and service providers inexperienced in psychosocial disability; and a lack of appropriate support services.

6.21 The committee believes that it is critical that the new psychosocial disability stream addresses these issues in rural and remote communities to ensure it meets its objective of improving access to the NDIS for people with a mental illness.

Recommendation 4

6.22 The committee recommends that the National Disability Insurance Agency ensure that the implementation of the psychosocial disability stream takes into account the issues facing rural and remote communities, including barriers to accessing mental health services and the lack of knowledge and experience in both psychosocial disability and the National Disability Insurance Scheme.

Funding services appropriately

6.23 The committee holds serious concerns about the short-term nature of funding cycles, noting the large number of mental health service providers facing uncertainty in funding. Limiting funding contracts for providers to 12 months at a time is having a detrimental impact on the provision and continuity of care in many rural and remote communities.

6.24 The committee also recognises that rural and remote communities are not suited to a competitive tendering process for service provision. The competitive tendering process favours city-based organisations with the capacity to provide rural and remote services at a financial loss. However, these organisations rarely have an understanding of communities and their needs and frequently do not have services 'on the ground' when they are awarded the contract. Local providers can't compete and the communities which they service lose out.

6.25 The committee is of the firm belief that funding cycles need to be of sufficient length to allow local service providers to develop infrastructure, attract and retain a suitable workforce, and build trust within a community, while also allowing for accountability and review processes within the contracted time period.

6.26 The committee therefore suggests that the minimum initial contract length be 5 years when funding mental health services in rural and remote communities and in the regional centres which service those communities. Furthermore, there should be options to extend a service provider's contract without additional tendering, following assessment of the efficacy and acceptability of the services provided to the local community.

Recommendation 5

6.27 The committee recommends that Commonwealth, State and Territory Governments should develop longer minimum contract lengths for commissioned mental health services in regional, rural and remote locations.

6.28 The committee also strongly believes that local knowledge and connection to the community should be major considerations when commissioning service providers in rural and remote areas. This could be demonstrated in a variety of ways, such as a high proportion of locally-based health workers, a local-workforce capacity-building strategy, and an ongoing community consultation forum with genuine input into design and decision-making.

Recommendation 6

6.29 The committee recommends that Commonwealth, State and Territory Governments should develop policies to allow mental health service contracts to be extended where a service provider can demonstrate the efficacy and suitability of the services provided, and a genuine connection to the local community.

Block funding

6.30 The committee recognises that restrictive fee-for-service models of funding combined with the loss of block funding, in many cases a result of the introduction of the Primary Health Network commissioning model and the implementation of the NDIS, has had a serious impact on the ability of small service providers in rural and remote areas to meet the overhead costs of running a service in these locations.

6.31 The committee believes that there has been market failure in rural and remote communities, making the current style of the NDIS rollout in these contexts a practical impossibility. The committee notes that the removal of block funding for long-established services creates significant risk for the individuals and communities who

have voiced genuine concern that no service will be available to them if rural or remote communities are forced to implement the current NDIS model.

6.32 Service providers in many rural and remote communities cannot offset overhead costs through other fee-based services as providers in urban centres are able to do and therefore rely on block funding for the long-term viability of their services. Without block funding, some providers have had to pull their trusted, established services out of rural and remote communities.

6.33 The committee agrees with the view that flexible block funding is also required for providers to adequately meet the unique and changing needs of each rural and remote community. What works in one community may not suit the next and providers need to be able to offer flexible services, such as community engagement, and supports, such as transport, to improve access and attendance.

Recommendation 7

6.34 The committee recommends that Commonwealth, State and Territory Governments consider the reestablishment of block funding for mental health services and service providers in regional, rural, and remote areas.

Stepped care

6.35 The committee received extensive evidence that the stepped care model of mental health service provision, while well-suited to urban centres, is failing in some rural and remote areas. For a number of communities visited by the committee, some of the 'steps' within the model are poorly accessible or missing entirely.

6.36 It is the role of Primary Health Networks to identify the needs of their local communities and commission services which address the gaps in the stepped care model. While the committee saw some excellent examples of regions where this has been successful, it holds concerns that not all Primary Health Networks are addressing the needs of their region adequately.

Recommendation 8

6.37 The committee recommends that the Commonwealth Government review the role of Primary Health Networks in commissioning mental health services under the stepped care model to ensure effective and appropriate service delivery in regional, rural and remote areas.

Improving access

6.38 The committee acknowledges the important role that telehealth plays in the delivery of mental health services to rural and remote areas, particularly through programs such as headspace and the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative.

6.39 However, the committee strongly believes that access to telecommunications infrastructure in rural and remote locations needs to be improved if telehealth initiatives are to be a viable alternative or supplement for face-to-face services in these areas.

6.40 The committee also heard concerns from some submitters that the way the Medicare Benefits Schedule (MBS) funds certain mental health and primary care services is also restricting the flexibility of providers and practitioners to offer the care needed by consumers in rural and remote communities, both face-to-face and via telehealth.

6.41 The committee considers that thought should be given to allowing capacity for MBS-funded psychology referrals from allied health professionals and nurses, such as Aboriginal Health Workers and remote area nurses, and for greater exemptions under section 19(2) of the *Health Insurance Act 1973* (Cth) to allow provision of MBS mental health services alongside services funded from other sources.

Recommendation 9

6.42 The committee recommends that the Commonwealth Government consider pathways for allied health professionals and nurses in rural and remote Australia to refer patients under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative.

Strengthening the strategic framework for Aboriginal and Torres Strait Islander mental health

6.43 Throughout the inquiry, the committee heard about the positive impact of Aboriginal Community Controlled Health Services and the role of an Aboriginal and Torres Strait Islander workforce in the delivery of mental health and wellbeing services for Aboriginal and Torres Strait Islander peoples.

6.44 The committee commends the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Aboriginal Mental Health Framework) as an invaluable tool to improve mental health services and notes that it is in the early stages of implementation. However, the committee notes with some concern that there does not yet appear to be a specific implementation plan for this strategy, a monitoring plan has not been developed and there is no explicit associated funding.

Recommendation 10

6.45 The committee recommends that the Commonwealth Government prioritise the development of implementation and evaluation plans for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*.

6.46 The committee notes that a key action area under the Aboriginal Mental Health Framework is to 'Strengthen the Foundations', in particular the development of effective partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services.

6.47 Evidence received by this committee is that only a limited number of Primary Health Networks have worked towards establishing such a partnership with the Aboriginal Community Controlled Health Service sector, despite clear evidence that

the preferred model of health service delivery for Aboriginal and Torres Strait Islander peoples is by Aboriginal Community Controlled Health Services.

6.48 The committee notes that there is a large body of evidence about the value of Aboriginal Community Control across the health sector and recognises that some states and territories are actively pursuing pathways for community control and partnerships which build capacity in communities.

6.49 However, Aboriginal Community Controlled Health Services reported to the committee that they face funding difficulties as service contracts are frequently given to non-local organisations that then seek to sub-contact portions of the work to the local Aboriginal Community Controlled Health Service as a junior partner with limited if any input into service design.

6.50 The committee strongly agrees with the statements of the Aboriginal Mental Health Framework that Aboriginal and Torres Strait Islander leadership, engagement and partnership in the planning, delivery, evaluation and measurement of services and programs is critical in fostering greater trust, connectivity, culturally appropriate care and effective outcomes. The committee believes that not enough has been done to ensure that this principal is put into practice in funding and service design.

Recommendation 11

6.51 The committee recommends the Commonwealth Government implement measures to ensure that services commissioned by Primary Health Networks embody the action plans of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* and are delivered by, or in genuine long-term partnerships with, Aboriginal Community Controlled Health Services and other Aboriginal and Torres Strait Islander community organisations.

Recommendation 12

6.52 The committee recommends that all Primary Health Networks have an Aboriginal and Torres Strait Islander member on their board.

Increasing professional workforce support

6.53 The committee heard time and again throughout this inquiry that the workforce is the backbone of mental health service delivery, and without a well-educated and well-resourced workforce, any strategy for mental health service delivery will be destined to fail.

6.54 The committee heard there is already a desperate shortage of urban-trained mental health specialists who are available to work in rural and remote locations and that, conversely, there is a lack of training opportunities for people living in rural and remote locations to upskill and fill those roles. The committee further heard that the ongoing registration requirements for health professionals are often difficult to meet in rural and remote locations.

6.55 The committee therefore believes there is a role for health professional colleges to develop programs to provide increased support to the rural and remote workforce, encouraging rural and remote rotations, incentivising placements and

supervision of junior staff, and providing continuing professional development in these regions.

6.56 However, the committee believes that a strategic approach must be taken to workforce development, which needs a multi-pronged approach to develop a sustainable and effective workforce into the future.

Recommendation 13

6.57 The committee recommends the Commonwealth Minister for Health work with health professional colleges to develop strategies for the immediate improvement of professional supports and clinical supervision for registered health practitioners working in rural and remote locations.

Cultural competency

6.58 Furthermore, the committee believes that the mental health workforce must be appropriately trained to meet the needs of diverse communities in rural and remote Australia, including by providing culturally competent mental health and wellbeing services.

6.59 The committee acknowledges that a one size fits all approach cannot be applied to cultural competence and that every community in Australia will have different needs and a different cultural context.

6.60 The committee heard throughout its inquiry the importance of patients, particularly Aboriginal and Torres Strait Islander peoples, having a positive initial interaction with mental health professionals to ensure patients return and continue to access support services.

6.61 The committee notes that culturally competent mental health services directly impact the health outcomes of Aboriginal and Torres Strait Islander peoples and is concerned by reports that the level of cultural competency of mental health services is inconsistent in rural and remote communities.

6.62 The committee firmly believes that service providers should offer training and accommodate continuing professional development for their staff in cultural competence which is informed by, and relevant to, their local community.

Recommendation 14

6.63 The committee recommends that all mental health service providers, including government and community sector, ensure their workforces are culturally competent and that such training be endorsed by and delivered in partnership with the communities into which they are embedded.

Fly-in fly-out services

6.64 The committee understands that for some communities, fly-in, fly-out (FIFO) mental health professionals provide valuable support to rural and remote communities which may otherwise not have access to mental health services, due to the shortage of mental health professionals in these communities.

6.65 However, the committee notes that like any other mental health services, FIFO services must be designed to meet the needs of the local community and be

supported by long-term investment which enables FIFO mental health professionals to provide reliable and regular services and build relationships and trust within the local community. The presence of a service provider on any day in a community ensures neither service provision nor the necessary continuity of care known to be critical in developing the trust required to underpin the therapeutic relationships fundamental to good mental health care and positive patient outcomes.

Recommendation 15

6.66 The committee recommends that all providers of fly-in, fly-out mental health services ensure that mental health professionals are supported by long-term investment to enable them to provide reliable and regular support services to rural and remote communities, with consistency of personnel an essential requirement for any service provider.

Peer support workers

6.67 In many of the communities it visited, the committee heard about the important role played by peer support workers, who provide support to people experiencing mental illness and often fill a gap left by the shortage of mental health professionals in rural and remote communities.

6.68 The committee notes that generally these support services are provided by people who have had their own lived experience with mental illness but have received no formal training in mental health support and are not employed or paid for the support services they provide. Many rural and remote communities rely on these outstanding members of the community to provide support to people in times of crisis and connect them to mental health resources.

Recommendation 16

6.69 The committee recommends that peer support workers be given appropriate training to enable them to continue their role in helping people experiencing mental health issues. The committee further considers that peer support workers should be recognised as a valuable support service by being paid to perform this role in rural and remote communities.

Reducing stigma in rural and remote communities

6.70 While one in five Australians will experience a mental illness in any given year, the stigma associated with mental health is still pervasive in Australia's rural and remote communities. The committee believes that stigma plays a major role in rural and remote communities accessing mental health services at a low rate.

6.71 The committee acknowledges that there are many factors which contribute to the ongoing stigma surrounding mental health. Many people told the committee that they did not seek help for their mental health issues either out of fear of facing discrimination about experiencing mental illness or because of the culture of self-reliance in rural and remote communities.

6.72 The committee heard time and time again that concerns about confidentiality and privacy prevented people from seeking support from local mental health services. People in rural and remote communities don't always feel comfortable speaking about

their mental health to a person they may also see in a social setting, or if they are not confident in the mental health professional's ability to maintain confidentiality. This often results in people travelling to the next town or a capital city to access mental health support services, or simply not seeking support at all.

6.73 In some communities, visiting a particular location in town was conspicuous and people in the community could easily deduce when a person was seeing a mental health professional. The committee heard that some communities are seeking to combat this issue by implementing the 'one door' approach which co-locates mental health services with other physical medical services.

6.74 The committee supports the use of the 'one door' approach in an effort to improve access to mental health service in rural and remote communities, but also believes that more must be done to educate the community about mental health in order to reduce the associated stigma.

6.75 This is particularly the case for vulnerable groups of people such as lesbian, gay, bisexual, transgender and intersex people, cultural and linguistic diverse populations and Aboriginal and Torres Strait Islander peoples. The committee believes that separate communication strategies which are specific to these vulnerable groups should be developed in recognition of the ongoing role of education in reducing the stigma associated with mental health.

6.76 The committee believes that co-design with these communities is critical to enable ongoing review and adaption of relevant public health services and messaging.

Recommendation 17

6.77 The committee recommends that Commonwealth, State and Territory Governments, as well as mental health service providers and local communities, continue to educate rural and remote communities about mental health and advertise local and digitally-available support services, with a view to reducing the associated stigma.

Recommendation 18

6.78 The committee recommends that Commonwealth, State and Territory Governments work with mental health service providers and local communities to co-design appropriate educational materials to reduce the stigma surrounding mental health in rural and remote communities.

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